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Ada-Maria Ahlgren

MULTIAGENCY COOPERATION BETWEEN MENTAL HEALTH CARE AND RESIDENTIAL CARE FOR CHILDREN AND ADOLESCENTS

– Qualitative focus group content analysis

TURUN AMMATTIKORKEAKOULU
TURKU UNIVERSITY OF APPLIED SCIENCES

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Heikki Ellilä

Ada-Maria Ahlgren

MULTIAGENCY COOPERATION BETWEEN MENTAL HEALTH CARE AND RESIDENTIAL CARE FOR CHILDREN AND ADOLESCENTS

The total of minors placed in substitute care in Finland in 2013 was 18 022. Many of these children exhibit behavioral and mental health problems. It is often required from child welfare to collaborate with mental health services to ensure that all the needs of minors in residential care are met. Due to this need it is important to examine the existing practices and policies in the communication between these different organizations, consider new policies and advance the cooperation between these organizations.

The focus group content analysis of this thesis has been produced for RESME- project. The international project is funded by the European Union in order to develop European residential care occupational know-how among child welfare and mental health employees. The focus group content analysis has been done by analyzing two mixed focus group interviews. The interviewees represent both mental health professionals and employees in residential care. The purpose of the interviews was to find already existing and functional practices in communication between child welfare and mental health services and identify the possible flaws.

The results show evidence of a variety of problems and functional practices in both the communication between the organizations and in the internal operating models.

KEYWORDS:

Mental health; minor; children; multiagency cooperation

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Heikki Ellilä

Ada-Maria Ahlgren

MONIAMMATILLINEN YHTEISTYÖ MIELENTERVEYSHOITOTYÖN- JA LASTENSUOJELUNLAITOKSISSA

Kaikkiaan kodin ulkopuolelle oli vuoden 2013 aikana sijoitettuna 18 022 lasta ja nuorta ja monella heistä ilmeni mielenterveysongelmia sekä ongelmakäyttytymistä. On tavallista että lastensuojelu tarvitsee yhteistyötä mielenterveyspalveluilta, turvatakseen sijoitettujen lasten kaikkien tarpeiden huomiomisen. Tästä tarpeesta johtuen on tärkeää tarkastella olemassa olevia käytäntöjä organisaatioden välisessä kommunikaatiossa, sekä pohtia uusia käytäntöjä ja edistää organissatioiden yhteistyötä.

Tämän opinnäytetyön laadullinen sisältöanalyysi on tehty RESME- projektille. Kyseessä on Euroopan Unionin rahoittama kansainvälinen projekti, jonka tarkoituksena on kehittää eurooppalaista lastenkotityön ammatillista osaamista kasvatus- ja mielenterveystyön rajapinnoilla. Laadullinen sisältöanalyysi on toteutettu kahden ryhmähaastattelun pohjalta, joissa paikalla oli psykiatrista hoitohenkilökuntaa, sekä lastensuojelulaitoksessa työskenteleviä sosiaalialan henkilökuntaa. Haastettalujen tarkoituksena oli kartoittaa olemassa olevia, ja toimivia malleja organisaatioiden välisessä kommunikaatiossa, sekä tunnistaa mahdolliset puutteet.

Tuloksista on löydettävissä erillaisia ongelmia ja toimivia ratkaisuja, sekä organisaatioiden välisessä kommunikaatiossa, että organisaatioiden sisäisissä toimintamalleissa.

ASIASANAT:

Mielenterveys; lapset ja nuoret; lastensuojelu; moniammatillinen yhteistyö;

CONTENT

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LIST OF ABBREVIATIONS (OR) SYMBOLS

M1	The M1- referral is involuntary psychiatric examination administered despite an individual's objections. (Suomalainen Lääkäriseura Duodecim 2009).
Valvira	National Supervisory Authority for Welfare and Health (Valvira 2015).

1 INTRODUCTION

In 2013, the total of minors placed in substitute care in Finland was 18 022, with an increase in emergency placements from 2005 (National Institute for Health and Welfare. Official statistics of Finland. 2014, 41), these numbers increasing from previous years. Some of these children suffer from a variety of mental health illnesses and disorders, leading to a need for multiagency cooperation between institutions handling the child's case.

The topic of well-being of children and adolescents has had increasing media coverage in Finland during recent years. The parliament of Finland has been working on budgets for preventative health care and inspecting the effectiveness of child and family welfare. Reforms in the Child Welfare Act have been made in recent years and studies concerning the well-being of children and families. However, very little focus has been given to the cooperation between agencies working with the children and adolescents.

There is a lack of education among the residential care workers on how to approach mental health problems. This can be seen as inability to handle a mental health illness the child has and a lack of interest in dealing with it, before an acute episode develops. These problems cumulate into the child psychiatric inpatient ward workers dealing with a child with personality- and behavior disorders, which cannot be treated in a short-term inpatient ward visit, rendering the care ineffective.

A mutual respect for each other's work between residential care workers and psychiatric inpatient ward workers is evident, but a need for education on mental health for the residential care workers, arises. Developing a customership in mental health care for the child or adolescent in residential care is lacking. This is due to issues identifying the need for care before acute episodes present themselves and a lack of education in the range of care which could be provided in such cases.

The present work is composed of a mixed focus group analysis. The analysis examines the content of two mixed group interviews, attended by residential care workers and psychiatric inpatient ward personnel. These interviews were conducted in order to find good and bad experiences between these professionals on the communication and cooperation of these agencies and find solutions or ideas for improvement.

2 RESME

The present work, composed of two different focus group interviews combined to one focus group content analysis is part of a bigger project known by the name of RESME. RESME is a comparative study of the cross disciplinary co-operation and communication between mental health systems and the welfare systems in five EU countries, especially concerning children and youth from residential homes who need help from both systems.

By researching and describing the challenges of cooperation between the two sectors or systems in five EU countries RESME aims to create a better understanding of the deeper logic in these challenges – and to promote change through educational programs and conferences that will focus on the challenges an present ‘best practice’ between the participating five EU countries.

The countries participating in the project are Lithuania, Germany, Spain, Scotland, Finland and Denmark.

Originally, four thesis works consisting of two systematic literature reviews and two qualitative focus group analyses were to be presented together under the general cover of RESME, so their results would complement each other; two of these works have been published together; one content analysis and a complementing systematic literature review, previously to this work, as its own work. This work is published as its own, same tools for content analysis were used for consistency, in order to promote the initial plan.

3 BACKGROUND

3.1 Taking children into out of home care in Finland

The Finnish Child Welfare Act 417/2007 safeguards the right of children to grow in a safe environment, to enjoy a balanced and well-rounded development, and to especial protection. It places the primary responsibility for a child's wellbeing on the child's parents and other custodians, although under certain conditions, a child may be placed away from home or other measures may be taken to arrange care for and custody of the child.

Three different possibilities are contemplated in the text, in its sections 37, 38 and 40, when placing children into substitute care. Two of these sections; 37 and 38 amended December of 2014 in The Finnish Child Welfare Act 1302/2014. The English translation was not available during the making of this thesis, so the modifications are a rough translation by the writer of this thesis.

Section 37: Placement as support in open care. If the child cannot be placed as support in open care in, their best interest, with their parent, custodian or other person in charge, placement as support in open care may also be arranged on a short-term basis for the child alone. Such placement requires the consent of the child's custodian and, if the child is twelve years of age or more, the consent of the child. The preconditions for the placement are that it is necessary for: 1) assessing the child's need for support; 2) rehabilitating the child; or 3) arranging care for the child temporarily on account of the custodian's or other person in charge's illness or similar condition.

Section 37 a: General prerequisite of placement as support in open care. The child cannot be placed repeatedly as support in open care, unless the welfare of the child necessitates a new placement.

Section 37 b: Emergency support action in open care. If a child is in immediate danger for a reason referred to in section 40 below, can support in open care be

arranged urgently, provided that the support action is in the interests of the child, suitable, possible and adequate.

Section 38: Emergency placement of a child. If a child is in immediate danger for a reason referred to in section 40 below, or is otherwise in need of urgent placement and substitute care, the child may be placed with urgency in family care or institutional care.

The decision on an emergency placement is made by the officeholder determined in accordance with section 13 subsection 1, and an emergency placement based on the officeholder's decision may last 30 days at most.

Notwithstanding what is provided in subsection 1 an emergency placement may last without a separate decision for more than 30 days if:

1) The officeholder determined in accordance with section 13 subsection 2 and 3 submits within 30 days from the start of the emergency placement an application for taking into care referred to in section 43 subsection 2 to an administrative court; or 2) proceedings in the case of taking into care have already been initiated at an administrative court or the Supreme Administrative Court before the decision on the child's emergency placement is made.

While an emergency placement is being undertaken, the municipal body responsible for social services is entitled to take decisions on the child's affairs to the extent necessary in view of the purpose of the emergency placement and in the manner laid down in section 45.

Section 38 a: Decision to extend emergency placement of a child. If 30 days is not an adequate period of time to investigate the need for emergency placement or to identify adequate support, officeholder determined in accordance with section 13 subsections 2 and 3 can make a decision to extend the placement for 30 days at most if:

1) a decision of necessary child protective action cannot be made without further clarification; 2) the necessary clarifications are not obtained within the 30

days of emergency placement 3) the extension is in the best interest of the child.

Section 38 subsection 2 is referred when deciding extension time period.

Section 40: Duty to take a child into care and provide substitute care.

1) If their health or development is seriously endangered by lack of care or other circumstances in which they are being brought up, or

2) They seriously endanger their health or development by abuse of intoxicants, by committing an illegal act other than minor offence or by any other comparable behavior.

There were 4 202 children in emergency placement in 2013, showing an increase of 6,6per cent from 2012. The number of children in emergency placement has been growing since 2005. All in all 18 022 children and young people were placed outside the home in 2013, which was just under one per cent more than the previous year. (THL 2014). Compared to the numbers of the previous publication there is still a growing trend among these numbers. Regardless of the increase in cases of this manner, a child can only be taken into provision and substitutive care if the measures referred in chapter 7 of the act –open care- are not met and the decision is estimated to be in the child's best interest.

Between the different alternatives of substitute care, one will be focused on for the purpose of this thesis; residential care, since the interviewees represent residential care workers.

3.2 Influential societal factors of children's well-being

The report by Social- and Welfare ministry of Finland, 2013, lists eleven points which consider the societal changes affecting the well-being of children, from the perspective of child protection services. Some of these changes are global and some characteristic for Finnish society. These changes contribute to the

amount of children and adolescents in need of residential care and foster care services.

1. The value of families with children and children has decreased in society

The interest of population policies has shifted from children and families with children to the working age and retired populations. For example the service structure reformation is focused on social- and welfare services catered to the ageing population of Finland, bypassing the services focusing in child care. It should be noted that even though there is a decrease in proportional number of children (increase in the ageing population) in population, the actual number of children has remained the same as has the need for basic social security in the 2000s.

2. Inequality and child poverty rise

The inequality in well-being among children and families with children degreased in the 1980's, but has started to increase since. Simultaneously as the majority has a good and well balanced childhood, a small, but increasing minority has an increase in indisposition.

Subsistence difficulties and severe childhood poverty have increased. Financial inequality has increased its prevalence in the children's ability to make social connections and maintaining them. The family's poverty restricts the ability to buy consumables needed for or attend hobbies.

The government services, which are considered to serve basic human needs (usually understood to include health and social services), have transformed from a communal services into a right of choice of consumers, has created a social-economic imbalance. The parents with better education and yearly income can choose elementary schools by district.

3. Mandate has changed from investment into budget cuts

Services and income redistribution for children and families with children was seen as an investment into the future in the 1990's and were not expected to

produce an instant profit. This view has changed, as municipalities see these investments as a consumption expenditure, which can be downsized with budget cuts, without consideration of the effects on child well-being.

4. The concept of a family with children are changing

The number of children who grow up into adulthood in a nuclear family consistent of both their biological parents has decreased. An increasing number of children grow up with changing sibling- and relative relationships. In Helsinki area alone, one in ten adolescents have two homes.

Substance abuse has always been a threat to a healthy and good childhood. The increase of alcohol and substance abuse among women has created new dimension to this problem. Children are placed into foster and substitute care, as the amount of services for mental health and substance abuse do not meet the need for care.

5. Challenges in parenting are increasing

The internet, games, television programming and movies have increased their meaning in educating children parallel to parents and other adults. Marketing towards children has increased, making them consumers. Advertising targeted to children creates brand awareness among young children, pressuring to acquire such items. This pressure is placed on both the child and their parents.

6. Demands placed on children and adolescents have increased

Children and adolescents are expected to make decisions and carry responsibility independently earlier. Traditional community has disbanded from junior high school and colleges. The amount of classroom teaching has decreased.

Employment requires education and professional expertise, while employment outlook is uncertain. A higher level of maturity is required for adulthood than previously.

7. Support networks for families with children have weakened

Constant moving and urbanization have changed the living circumstances alienating generations from each other. The changes obstruct creating essential relationships with neighbors. The significance of extended family supporting families with children has decreased.

8. Increase of multiculturalism

Children of multicultural backgrounds are increasing in numbers in Finland. Planning of societal changes and services is facing a challenge of focusing revisions to areas of multiculturalism and suffer from child poverty. All services directed to families with children and children, are in a need of multicultural expertize.

9. Problem orientation grows stronger

In research and development, families with children and children are examined from a problem oriented viewpoint. Problems and their risk factors are identified earlier. Simultaneously, disorder and problem oriented individual therapy and communal interventions are developed.

The mass media focuses on tragedies and problems surrounding families with children and children. Thus increasing the problem orientation in societal discussion and decision making.

10. Definition of normality diminishes

The understanding concerning the differences in families with children and children has diminished. When problem oriented expertize increases, the differences or deviation in average development of a child can be interpreted as a problem.

11. Problems accumulate and shift from generation to generation

One risk factor or problem doesn’t necessarily danger a normal childhood. The more problems accumulate on a child or a family with children, the poorer is the prediction. Indisposition problems and risk factors accumulating on the same families or children has increased. When a child grows up in a family with multi-

ple accumulated indispositions, the prejudice to a poor way of life shifts from generation to generation.

According to the report by Social- and Welfare ministry of Finland, on a municipal level, when the goals of child protective services cannot be met, the largest single reason is the continuous growth of the strain on child welfare workers and lack of adequate staff. The strain for child protective services has tripled in the last two decades, whereas the amount of child welfare workers has not increased. This is also evident in the content analysis, when topics of under staffing and an increase in workload could be observed.

4 AIM AND PURPOSE

The purpose of this bachelor thesis work is to explore the current situation of cooperation between residential care and the mental health services provided to children and adolescents in the residential care setting. The aim is to find good practices between these operators and to find solutions to improve inoperative practices through experiences of Child Protection and Child Psychiatry professionals dealing with the same clientele; youth placed in residential care in need of mental health services.

The research questions of this thesis are:

- What are the good practices in cooperation between residential care providers and mental health care providers?
- What is considered problematic in cooperation between these operators?
- What can be developed to solve these problems or prevent them?

5 QUALITATIVE MIXED FOCUS GROUP CONTENT ANALYSIS

5.1 Research design of the mixed group content analysis

The research design of the study was qualitative and inductive content analysis of a semi structured focus group interview.

5.1.1 Focus group interview

Focus group interview is a method to be used, when the research has got the aim, as it was with this project, to find out current good practices and when there is a need to quickly gather information from many interviewees. The aim is told to the participants before the interview. The participants of the focus groups were carefully selected according to chosen criteria. Focus group is commonly used model, when seeking to develop new ideas. (Hirsjärvi and Hurme. 2009, 62-63.) The use of focus group in this study is justified as it suits well for the RESME projects aim to develop new ideas for cooperation between two services.

During the discussion, the interviewer pursues to create a relaxed atmosphere in order to participants to feel free to open up (Hirsjärvi and Hurme. 2009, 62). Thus, a person centered approach was applied by interviewers as they used open ended questioning and strived to understand participants through their frame of references. In addition, they tried to convey that understanding to participants by checking their comprehension and asking clarification by using focused questions. The interviews were semi-structured as non-structural and semi-structural methods were used. For instance, non-structural open questions were used and the interviewers with their responses took the answers deeper and let the answers (interviewees) to lead the interview forward.

During the first interview in 13.3. the focus of discussion was the problems in current practices and in the second interview a week later, 20.3., the focus was on the positive experiences and good practices. Both full lists of characters used in transcription can be found in appendix 1 and appendix 2.

5.1.2 Content analysis

Qualitative content analysis used in nursing research and education is one of the principal usages of the method of content analysis (Graneheim and Lundman 2004, 105). It also suits well with inductive approach applied in the research, as in inductive analysis, the studied material is the base for conclusions and it dictate the direction the research will take (Hirsjärvi and Hurme. 2009, 136). These methods were also chosen for this study to keep a consistency with other studies based on RESME project interviews (Cobo-Carretero and Kuosa 2014).

To make sure everything of significance was kept through the content analysis process, the person centered approach was applied to it. There were possibilities of losing content in the condensing and translating parts of the process, so importance on possible latent content was also carefully considered. Currently there are various uses of concepts and terms within qualitative content analysis, so it was decided to follow methods and terms Graneheim and Lundman (2004, 105-112). This helped in keeping consistency with Cobo-carretero and Kuosa by using same tools and terminology as the previous, similar, process.

Used terms in the analysis

Manifest content= the content of the text which is visible.

Latent content= underlying meaning of the text or the message conveyed through non-verbal communication e.g. the tone of the voice.

Meaning unit= a piece of text, varied in length, in which the words, sentences or paragraphs are related to each other by their content and context.

Condensed meaning unit= a meaning unit which is (possibly) reduced in length, but still persevere its core meaning. Likewise, sometimes other way round, the text becomes longer as the latent content of the material is written visible.

Abstraction= the process of arranging the text material and creating themes, categories and codes.

Code= the classifying name to given for a meaning unit.

Category= a cluster of content sharing commonalities under the same heading.

Theme= links underlying meanings (latent content) together. The process of content analysis the material is condensed in order to be able to handle it and to see or produce connections between different factors (Silius 2005, 3-4).

5.2 Sample

The research sample varied a little between the two conducted interviews. The first interview of 13th of March 2013 consisted of two interviewees from the field of psychiatry and three interviewees from residential care institutions. The second interview conducted on 20th of March 2013 had a higher attendance, with three interviewees from the field of psychiatry and three interviewees from residential care institutions. The requirement for participation in the interviews was having a minimum of five years of work experience in their respected fields.

All participants had had experiences about working with social services and each other's respected fields. Some participants had already had a collaborative experience with each other's institutions.

5.3 Data collection and analysis

The material for the content analysis was gathered from two mixed group interviews and analyzed from written transcriptions of the recorded interviews, then combined into one result table.

5.3.1 Interviews

The two interviews were conducted a week apart from each other; the 13th of March and the 20th of March. Both interviews were held in a conference room in Turku University of Applied Sciences premises. The first interview had five participants out of the intended six, excluding the interviewers, and took an hour and twenty minutes. In the second interview all six participants (interviewees) were present and also lasted one hour and twenty minutes.

In the beginning of both interviews the participants were shortly told about the project by one of the interviewers, a member of the RESME project. In the beginning of the second interview a short reminder and roundup of the topic(s) discussed during the week before, in order to have a natural flow between the two interviews. The interviewers also reminded about the voluntary nature and the confidentiality of the interview.

Both interviews also began with a short introduction by each participant, including the interviewers, in order to make the transcription process easier and to relax the atmosphere. After the introductions the participants began to freely express their ideas and no methods were used to give turns for the participants' statements. This proved functional for keeping the atmosphere relaxed and for the interviewees to have a sense of being able to express themselves freely. It proved to be slightly impractical for the transcription process, as there were some overlapping during statements, which hindered the accuracy.

The interviews proceeded to be coherent and the interviewees continued on each other's statements and ideas freely. The interviewers only guided the conversations on few occasions during both interviews, in cases where the conversation would come to a halt or a new topic would like to be introduced into the conversation. The participants complemented each other's statements by adding or correcting the statements made before and this created a cohesive dialogue.

5.3.2 Data analysis

The data analysis begun with the transcription of the two recorded interviews. The two interviews were to be transcribed by two different authors, but due to the inability to maintain with the planned schedule, it was decided that both interviews are transcribed by the same person. This decision was helpful in keeping consistency with the transcriptions as a level was chosen. (Hirsjärvi and Nurme. 2009, 139). Using the same source for data analysis and guidelines also helped in maintaining a similar methodology as in the previously published RESME content analysis thesis (Cobo-Carretero and Kuosa. 2014). Similarly to the before mentioned previous work, a low level of accuracy for the transcription was chosen, considering the importance of sentence formation was not as great as the meaning of the sentence. Therefore, some repeated words or stuttering was edited out. Strict care was taken to keep the meaning of the text by transcribing messy or broken sentences completely, to ensure no covert content is lost in the transcription process. The characters used for transcriptions can be found in appendix 1 and appendix 2.

After both transcriptions were complete, both were assessed through and each participant was given a number, according to time used per interview. The person using most time during an interview was given number one, the second longest used time received number two etc.

Editing the transcription material was started with classifying the material into categories, which created the frame for the material to be condensed later (Hirsijärvi and Hurme. 2009, 147). Both transcriptions were then divided into three main categories: good, bad, and ideas. These categories were chosen in collaborations with author Kuosa, when the transcription process was finalized. This categorization complements the aim of the RESME project.

As the material was processed into numbers for each participant, it became evident that all interviewees had contributed to all main categories. This clarified that the material could be used as a whole and attention to individual statements were not needed, thus excluding the previous numbering system.

Table 1. Categorizing and condensing the materials.

GOOD	BAD	IDEAS	MAIN DISCUSSION TOPICS
lkv dspiovujd snsjdpai piosad	lkv dspiovujd snsjdpai piosad	lkv dspiovujd snsjdpai piosad	**Unedited text themes**
lkv dspiovujd snsjdpai piosad	lkv dspiovujd snsjdpai piosad	lkv dspiovujd snsjdpai piosad	
lkv dspiovujd snsjdpai piosad	lkv dspiovujd snsjdpai piosad	lkv dspiovujd snsjdpai piosad	
GOOD	**BAD**	**IDEAS**	**MAIN DISCUSSION TOPICS**
dspiovujd snsjdpai piosad	dspiovujd snsjdpai piosad	dspiovujd snsjdpai piosad	**Unedited text compressed to abstract themes**
dspiovujd snsjdpai piosad	dspiovujd snsjdpai piosad	dspiovujd snsjdpai piosad	
dspiovujd snsjdpai piosad	dspiovujd snsjdpai piosad	dspiovujd snsjdpai piosad	
GOOD	**BAD**	**IDEAS**	**MAIN DISCUSSION TOPICS**
snsjdpai piosad	snsjdpai piosad	snsjdpai piosad	**Compressed themes from transcription**
snsjdpai piosad	snsjdpai piosad	snsjdpai piosad	
snsjdpai piosad	snsjdpai piosad	snsjdpai piosad	

The categorizing process was continued as illustrated in table 1. The text was condensed into a few phrases per category, or meaning units. This enabled for further examination per category and going through the individual statements, comparing them to the existing categories, to make sure everything of importance would be included in the end result. It was decided that the translation process from Finnish to English would be most suitable at this point of the work. The translation of the meaning units, divided into three categories, would ensure that nothing would be lost in the later condensing and coding part of the work. The translated material would be added to its own table so the two finished tables could be compared with each other's, illustrated in table 2.

Table 2. Comparative Finnish-English translation

GOOD	BAD	IDEAS	MAIN DISCUSSION TOPICS
lkv dspiovujd snsjdpai piosad	lkv dspiovujd snsjdpai piosad	lkv dspiovujd snsjdpai piosad	**Meaning units in**
lkv dspiovujd	lkv dspiovujd	lkv dspiovujd	

snsjdpai piosad	snsjdpai piosad	snsjdpai piosad	**Finnish**
lkv dspiovujd snsjdpai piosad	lkv dspiovujd snsjdpai piosad	lkv dspiovujd snsjdpai piosad	
GOOD	**BAD**	**IDEAS**	**MAIN DISCUSSION TOPICS**
dspiovujd snsjdpai piosad	dspiovujd snsjdpai piosad	dspiovujd snsjdpai piosad	**Word to word translation in English**
dspiovujd snsjdpai piosad	dspiovujd snsjdpai piosad	dspiovujd snsjdpai piosad	
dspiovujd snsjdpai piosad	dspiovujd snsjdpai piosad	dspiovujd snsjdpai piosad	

After the translations were finished, they were condensed once more, in order to edit out whole sentences from the categories, but keeping all the information and meanings as untouched as possible. After a satisfying result of condensed information was reached, sub-categories were given according to the meaning units of the content. The category good received two sub-categories, bad and ideas categories received three sub-categories both. This can be observed below in table 3.

Table 3. Creating sub-categories.

GOOD		**BAD**			**IDEAS**			**MAIN DISCUSSION TOPICS**
Ab	**Cd**	**Hi**	**Jk**	**Lm**	**Kq**	**Cp**	**Kh**	**Subcategories**
mdflaps	mdflaps	psxcn asip	psxcn asip	mdflaps	psxcn asip	mdflaps	psxcn asip	**Condensed information**
psxcn asip	mdflaps	psxcn asip	psxcn asip	mdflaps	psxcn asip	psxcn asip	mdflaps	

The table 4 illustrates how the material in sub-categories was organized into code-categories. For example, the category of good has now two sub-categories and the sub-category one has seven code-categories.

Table 4. Creating code categories.

	Main categories							
	1. GOOD		2. BAD			3. IDEAS		
	Sub-categories		Sub-categories			Sub-categories		
	1.1	1.2	2.1	2.2	2.3	3.1	3.2	3.3
CODE CATEGORIES	1. mpdsijh	1. mcdpsd pdsifh	1. dslfnk	1. mdpa o	1. nasldh	1. ndaosid soahdi spoidh	1. smdpa alsdj nfdaousy	1. dnm aölsi u aslö
	2. cndkls dnmapiw sbncxjkasy d siduhy	2. öaslduj döasljd öalsdj ösaldu	2. ndslkah laskdh as	2. söaj-dfa öaslkj dapio	2. sdalm adkasjldu asldkjas	2. dmaöska aclxui dlöaosu	2. aljdaoips aiwehg qpoey	2. na-osd y aksj dga iau w
	3. xkajsgd lsakdha lisdcy	3. aslkdh lcxhas	3. cnaisyd akdh	3. nmcik xwsd sia-dya	3. amxcdöps a xdchisa		3. xcnzs laksdh dhcaoi	
	4. cmc oxs vcjsopdf	4. cnsopidf nfcsoiedf h	4. ncslde cnose	4. cmpd	4. cnpis ncxoas	3. xnaios nxcoasud h		3. cno sdiu
	5. vcjspod	5. cbnsouid bsideuftg	5. shdfco	5. nxao uisyd	5. xcnboas	4. dbaousgd a	4. xnauwsty mp oisdy	4. xo-an xhn aos ued
	6. xaxcnpai xmaopi	6. xnao ahsxo	6. xnoaw		6. xbakis ncosa		5. cn soau hdoaw hdoicdsa	5. nc xo-zisy nxia
	7. cnosai cnosa awioe		7. cnosied hnbxucyw a siudy	6. miws epu xjnpi woa		5. xnoawi nbxouaw buxdoaw	6. xniaopw nxouaw	6. xnzi oqw owq nmo iy

After the materials were divided into the code-categories, each category could have similar meaning units in multiple code-categories. The meaning units were then once more inspected, in order to combine them under the same code-

categories. This reduced the number of the code-categories substantially. Similarities where then found and the code-categories could be interrelated together and added under similar headings. These headings are called a *code.* The full list of codes can be seen at appendix 3.

The last part of the content analysis was to examine the interaction of the created three main categories, to find the connections or discrepancies within the result material and giving interpretation for the results found (Hirsjärvi and Hurme. 2009, 149-151). This will be further explained in *Results for the qualitative mixed focus group content analysis.*

6 RESULTS FOR THE QUALITATIVE MIXED FOCUS GROUP CONTENT ANALYSIS

The categories formed in the analyzing process are compatible with each other's and form an interaction among themselves. These interactions form a pattern where the good practices are recognized and of help with prevention of weak- or inoperative practices. (See Figure 1.).

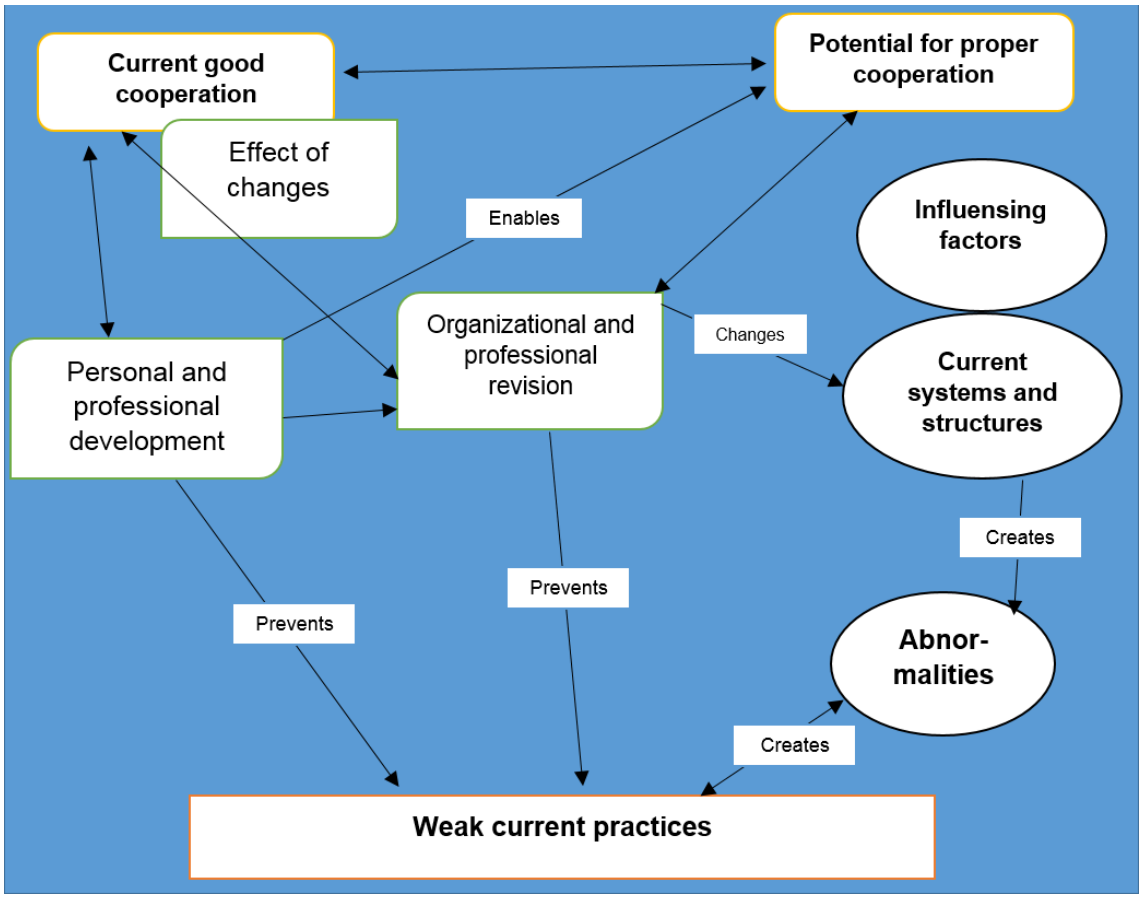

Figure 1. Interaction between different categories.

There is an interaction to be observed between the good practices and the organizational and professional development. Understanding the shortcomings of current practice as well as finding the positive and good of current practice helps to prevent weak current practices and also to discover the catalyst for the abnormalities. There is also interaction between the potential for proper cooper-

ation and current good cooperation. These three together prevent weak current practices and changes the current systems and structures.

6.1 Good cooperation

The results showed one strong existing factor of current good operation and from that arose the potentials for continuous good operation. The potential for good operation are resources which already exist, but are not used in their full potential. Both of these categories had several codes beneath them, which are illustrated below. (See Figure 2.).

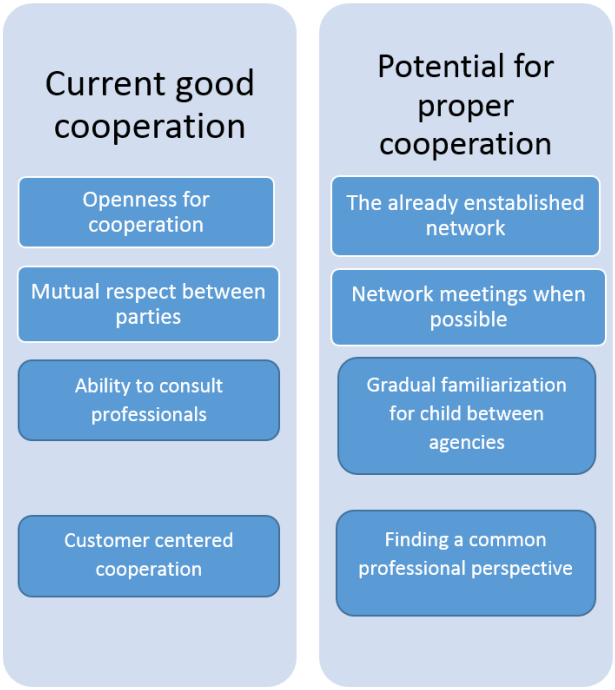

Figure 2. Results for current good operation.

6.1.1 Current good operation

The current good cooperation had four codes as listed:

- Openness for cooperation
- Mutual respect between parties

- Ability to consult professionals
- Customer centered cooperation

Openness for cooperation

Both child welfare and psychiatric professionals felt cooperation among each other as a resource and as an asset. This possibility was introduced during the first interview by the psychiatric personnel and well received by the child welfare workers. A possibility for phone consultations was offered, and its availability was made aware.

Mutual respect between parties

It was clear during the interview that the interviewees respected each other's fields and due to prior contacts were aware of the others complexities of work.

The conclusion was that both parties found the aspects of care from both sides need to be taken into consideration when planning care for children and adolescents.

Ability to consult professionals

As discussed briefly in *Openness for cooperation*, the possibility of consulting the psychiatric professionals during an incidence with a child, was brought up during the interview. This was well-received among the child welfare workers, who brought up cases where they felt they were not able to handle a certain mental health related situations. The discussion circulated around cases of children who have manifested self-harm intentions. The child welfare professionals felt ill-equipped to handle these situations on their own and expressed a lack of trust in the process of which these cases might be handled by municipal clinic on-call doctors. The offer of consult calls gave the child welfare workers a useful and usable tool for these types of cases.

Customer centered cooperation

Both professionals agreed that they work with the interest of the child as their priority.

6.1.2 Potential for proper cooperation

Already established network

There arouse many already established networks between people who work with children during the interviews. Cases where the child has customership with a specialized health care service or specialized child welfare institutions. There was a knowledge of the different possibilities prominent during the conversation.

Network meetings when possible

One participant expressed that a practice where the child is present with their mental health care worker and social worker is sometimes used. This practice resonated with the interviewees and was seen as a productive and good practice. The restriction for this practice was resource scarcity.

Gradual familiarization of child between agencies

Cases arouse during the interview where a child became a customer of mental health services first, and a placement in child welfare services followed after. When this is the case and it was possible, the transition from home or inpatient ward into a child welfare institution was done gradually. This was seen to have a less traumatizing effect on the child. The transition was done by introducing the child to the institution and staff gradually. This practice also helped with the decision if the child is well-matched with the institution and if the staff is able to handle the case. It was seen by the interviewees to be a good practice to reduce the interchange between institutions.

Finding a common professional perspective

Although respect was prominent between the professionals, the differences of perspective in care was considered during the interview. The different aspects of care from the organizations of the child were discussed; the psychiatric side has a more medical and clinical approach of the client and the residential care workers a more educational and everyday approach. It was stated by a psychia-

try professional that they tend to approach the client from the perspective of the illness, whereas the welfare sides approach is more of upbringing. Common ground was found when inspecting the daily routines and the patient centered approach.

6.2 The aspects of bad cooperation was divided into three categories:

- Systems and structures
- Influencing factors
- Abnormalities

These categories interact with each other and create a cycle which leads to bad practices. The systems and structures with influencing factors created abnormalities in protocol and practice, which in turn leads to bad implementation.

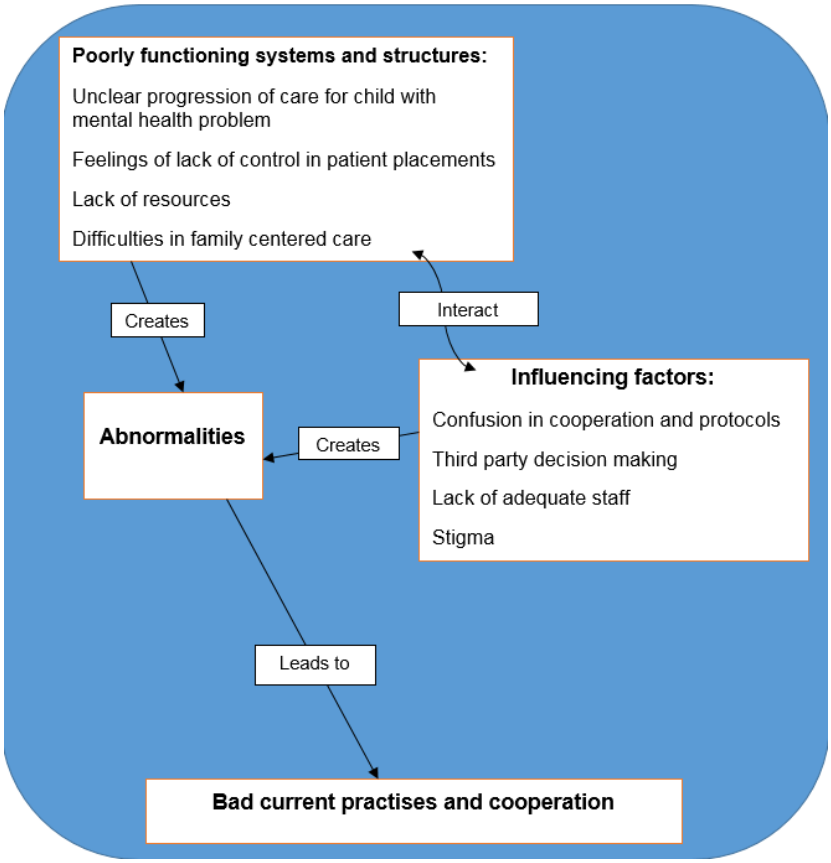

Figure 3. Interaction of problems and bad practices

6.2.1 Systems and structures

The problems with systems and structures which arose from the experiences of the interviewees were divided into four codes:

- Unclear progression of care for child with mental health problem
- Feelings of lack of control in patient placements
- Lack of resources
- Difficulties in family centered care

Unclear progression of care for child with mental health problem

In cases where the child was a client of a child welfare institution and began manifesting mental health issues while in care, the initiation of customership with mental health services was seen defective. The cases which arouse in the discussion were around children who manifested sudden suicidal or self-harm acts and children with personality disorders, which escalated into an acute episode.

There was very little discussion of cases which had contact to mental health care services prior to an acute episode. The progression was seen as sudden, the child would threaten with self-harm or harm the staff of the child welfare institution. In these cases, help was sought from municipal health care doctors, who would write a M1-referral (see list of abbreviations), if the child still seemed insistent on self-harm. The referral would lead to a psychiatric inpatient ward for an assessment. This was seen to be a cycle where the child would be taken from the institution to the inpatient ward for a short period of time, returned to the residential care institution and when the child has another acute episode, sent back to the inpatient ward.

It was agreed by both professionals that this cycle was not beneficial for the child and would not help with the underlying problem(s).

Feelings of lack of control in patient placements

A worry of right patient placement manifested during the conversation. The psychiatry professionals felt they had very little interaction with the social worker in charge of placement decisions. There was a sense from the residential care workers that they are not able to influence the decision which institution the child is placed. Examples of children who are placed in certain institutions by the child's social worker, without consult from the institution, were given. The child welfare professionals felt they had very little or no say in the placement matters since the final decision is done by the child's own social worker.

It was theorized by the interviewees that seen how the child welfare social workers had most likely excessive work on their hand, they might not consider the placement of the child through what it best for the child, but rather place the child where there is a place available.

In cases where the child was living at home with parents or care takers and the child was admitted into a psychiatric inpatient ward, it was discussed that in certain cases the psychiatric professionals would give a recommendation for the child to be taken out of their home. The information would be given to the child's social worker, but since a customership in a residential care institution was not yet established, the information would not be relayed there.

Lack of resources

Lack of resources was seen as a major contributor of problems. Both professional fields felt they are over worked and under staffed. They manage with current amount of staff during normal days, but when something out of the ordinary happens, there isn't enough staff to handle the situation. There was also a mutual feeling that with more recourses hiring specialized staff would help with communication and cooperation gaps. The psychiatry professionals suggested an added social worker, a rehabilitation instructor and a bachelor of social services would be a supportive addition between the cooperation of residential care workers and adolescent mental health services.

Increase in resources was also seen as a mandate for educating the staff of both parties and raising awareness for multiagency cooperation. Earlier cus-

tomership for adolescents in need of mental health services was discussed, in the form of interval care. This was seen as an effective method of patient centered multiagency cooperation, but a service the inpatient ward is not able to offer.

In addition to staff shortage, it was discussed that there is a need for education for the current staff. This will be further discussed in *Lack of adequate staff*.

Difficulties in family centered care

With family centered care, some connections between multiple parties; parents, child his/herself, child welfare worker, psychiatry professional etc. advancing their own agendas manifested as obstructed communication lanes. These lanes could be blocked by request of the child or adolescent or their parents.

In some cases, the child welfare professionals found it useful to have a possibility to discuss a child's case with the care-plan maker from the psychiatry professionals. This information could not be passed on because medical case summaries are not written by the psychiatry staff and when a care summary is made, it is given to the child's social worker, who might not relay the information onto the staff of the children's home. This would hinder the effectiveness of treatment in inpatient ward during the daily routines in children's home.

Some rare cases of hostility from the parents' side was experienced, but this was in minority of cases, and was not felt to be a significant problem. This will be discussed in more detail under *Influencing factors.*

6.2.2 Influencing factors

The influencing factors were divided into four codes:

- Confusion in cooperation and protocols
- Third party decision making
- Lack of adequate staff
- Stigma

Confusion in cooperation and protocols

Staff members from both organizations showed a significant knowledge of the child protection laws of the Child Welfare Act. There was a gap in knowledge about how the parties could interact and in which cases. As discussed in *Unclear progression of care for child with mental health problem*, the cycle of getting help for the child only when an acute mental health episode had manifested was deemed ineffective by both residential care workers and psychiatry professionals. This problem arouse mainly from a lack of knowledge in who to contact, when a child has mental health issues, which need specialized attention.

The child was taken into municipal health centers for a doctor's evaluation on the acute cases. With the M1- referral the child was taken to the inpatient ward, where an assessment of the situation was made. It was discussed that contact from residential care workers on behalf of the child should be made into a psychiatric out-patient clinic, where continuous care could be initiated.

Third party decision making

There was a consensus that considering the cooperation between only the psychiatry inpatient ward and children's home was fair. However, when the child's social worker was included in the conversation, an obstruction in communication could be observed. As explained further in *Feelings of lack of control in patient placements* there was a sense of inability to provide professional opinions when it came to the child's placement. The level of familiarity of different residential care institutions and a child's home life the child's social worker has, was questioned as well. Examples were given by a residential worker where the child's own social worker was not aware of the child's home life, and after residential care placement, the workers found out the child's background and family relationships through interaction with the child and their parents, instead of being briefed by the child's own social worker. This demonstrated a lack of trust in communication and information referral between the residential care workers and social workers. A similar example was also given by the psychiatry staff.

The qualifications of the on-call doctor of the municipal health center to make decisions of a child's mental well-being, was also in question, by both, the psychiatry professionals and the child welfare professionals. In acute cases where the child showed aggression towards the child welfare workers or threatened with self-harm, the child would be taken to a municipal health center, where an on-call doctor would assess the need for mental health care. The doctor might not have any background on mental health, so the qualifications of making and M1-referral decision are in question.

Lack of adequate staff

Both the psychiatric staff and the residential care workers expressed a need for more employees or a need for education to understand and better the communication between the respected workers. There was a suggestion from the psychiatric side to increase the knowledge about the child welfare side by hiring someone with an education of the social work side, to the inpatient ward. This was seen to advance the possibility to better communicate if the child is placed in a residential care setting, with the staff.

There could be a shortage on education of mental health on the residential care staff. A nurse is present in the residential care home, but they might not have specialized education on mental health. This education was also hoped for the social welfare workers, to be able to assess situations on their own and diffuse cases, when possible, on their own.

The psychiatric workers also raised an issue of when a child or adolescent was admitted to the inpatient ward during service hours, without a convoy from the residential care home. It was seen as an obstruction when planning a care plan and assessment for the child, when a person who works with the child daily, was not present to give their point of view for the admittance process.

Stigma

The problem of being stigmatized when receiving a mental health illness diagnosis or care for a mental health problem, was mostly seen as a problem to

arise when the child still lives at home. It was seen by the psychiatric staff that the problem of negative view of mental health services, or the need for these services, were almost exclusively of the parents. The parents might be in denial of the need for the care and state no such connections are needed for the child.

The residential care workers addressed a problem of stigma based on previous visits in inpatient ward or the child's background. It was also seen that the child's parents might have negative opinion about getting the child help from mental health professionals. While the parents cannot deny treatment when it is required, the residential care workers pointed out that their facility respects the views of the parents, and they are encouraged to be involved in the child's life. This was not seen as completely making a connection to mental health services impossible, but raising the threshold to contact the services, before an acute episode escalates.

6.2.3 Abnormalities

Abnormalities was divided into four codes:

- Obscurity in patient privacy practice
- Decisions for care made without adequate knowledge
- Rushed care decisions
- Parents negative attitude towards staff

Obscurity in patient privacy practice

This was seen as a major influence in communication difficulties between these agencies. The adolescent could legally restrict what information can be shared about them between different agencies. When there was not a possibility of a network meeting, which the child could attend, between the psychiatric staff and the residential care workers, it was felt the information of care of the patient could not be sufficiently relayed to the residential care home staff without breaking the patient privacy laws.

Decisions for care made without adequate knowledge

This concern manifested mostly among the residential care workers. It was felt, due to lack of education about mental health, that the decision to get help for a child or adolescent in need for psychiatric services was not done early enough or proficiently. The workers felt they need better support in the decision making process, to enable earlier contact to mental health services and define when there is a need for the contact.

It was felt that this lack a protocol and evidence based action led to unnecessary visits to psychiatry inpatient ward.

Rushed care decisions

An idea that the child will be cured of a mental health problem by an inpatient ward visit was discussed. A view where if the child is placed in a psychiatry inpatient ward and after a short stay there, would return to the residential care home healthy, could be observed.

Cases where the inpatient ward stay would be used as an intimidation tool for the child or adolescent was also discussed. In these cases the child would exhibit self-harm or threaten with self-harm frequently, the residential care staff would take the child to municipal health center for a referral to an inpatient ward or intimidate the child of this process. The child might take back their assertion to self-harm before taken into the health center, or at latest, when seeing the inpatient ward.

These last resort decisions contribute to the work load of all agencies involved, and were not seen as a conductive way to help the child or their situation.

Parents negative attitude towards staff

Some situations where the child is in need of a placement in either out of home care or a customership to mental health services, a hostility towards the professionals was discussed. Although the residential care workers work from a family centered angle, the frustrations and hostility from the parents part was viewed

as extremely counterproductive way to fulfil the child's rights to all types of care and the child's right to a well-rounded childhood. The hostility also obstructed the family centered care, since finding a way to communicate with a hostile parent could be difficult, hindered the possibility to a neutral and objective discussion of the child's needs.

6.3 Ideas to better multiagency communication

The ideas to advance cooperation and good communication was divided into three codes:

- What will/should changes affect?
- Organizational and professional revision
- Personal and professional development

These codes define the lacks in communication and give ideas onto the repair of the flaws. They give an idea where the improvement is needed and what could be done to improve the situation. (See Figure 4. below)

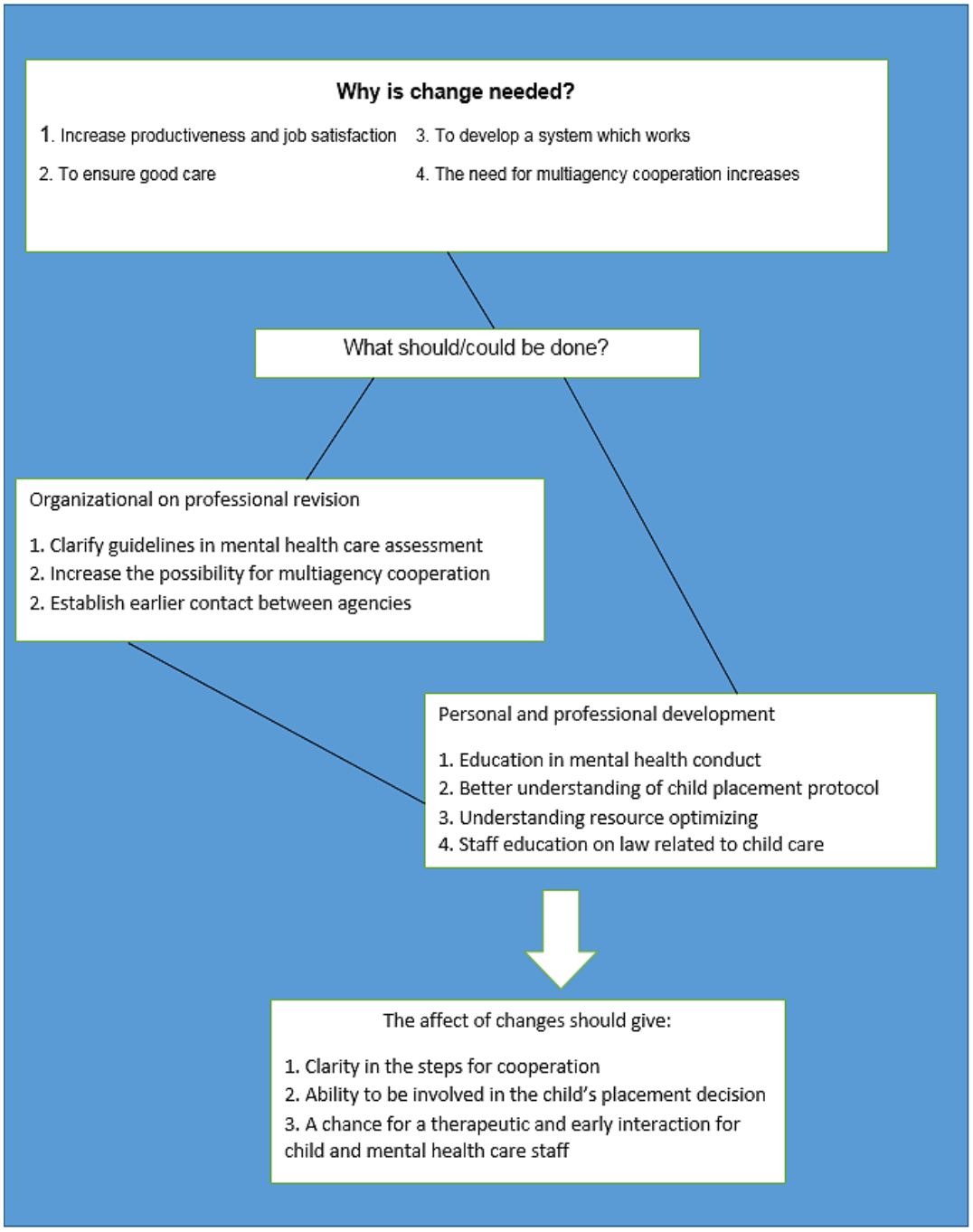

Figure 4. Results of ideas to better cooperation and communication.

The ideas section identifies the needs for changes and what changes should be made to better current cooperation and communication. These changes have also an ideal affect to be had on the cooperation and communication practices.

6.3.1 What will/should changes affect?

Clarify the steps for cooperation

The changes should bring clarity for which organization to be cooperated with in each situation. Fairly little cooperation was established between the psychiatric inpatient ward and residential care institution, because the child's mental health care would be transferred to outpatient services after inpatient ward care. The institutions would only interact again if the child had a recurrence of an acute episode and needed new care on the inpatient ward.

Ability to be involved in child placement decisions

Ability to effect the child's placement to a residential care home through the child's social worker was wished by both the psychiatric professionals and the residential care workers. This was seen to lessen the need for replacements of the child to different residential care institutions and frustration of the staff of feelings of lack in control in these matters. If the staff was able to have an influence on the placement consideration process done by the social worker, a referral to the right place of care could be established with less trouble.

Therapeutic and early interaction for child and mental health care staff

Cooperation was hoped to be established before acute episodes. It was felt that the after care or a continuous customership in the outpatient mental health care could be overlooked, when a cycle of; acute episode- inpatient care – back to residential care was the case.

6.3.2 Organizational and professional revision

The conjunctive cases in the revision was to find clarity to protocols of each other's organizations. A better understanding of how the other organization works, helps to bring clarity in multiagency cooperation.

Clear guidelines for mental health care assessment

The residential care workers felt unable to assess mental health related problems on their own, and felt the process was unclear of who to contact. An idea of a continuous supervision of a child's mental health state in the residential care setting was hoped. The process of getting a referral to mental health care institutions was seen as messy, this can also be attributed to the fact that the staff might not be knowledgeable about the Mental Health Act.

It was discussed that the residential care institutions also have cooperation with private sector mental health care providers, which contributed into the confusion of the protocols on who to contact.

More possibilities for multiagency cooperation

Due to lack of resources, it was seen that the possibility for network meetings between residential and psychiatry staff were poor. As a point of development, it was discussed that an experiment where staff members between agencies could change places with each other's for a period of time. This could reveal the conducts of the other agency in a concrete way and help with future cooperation.

Regular meetings between the agencies, which are not related to a specific child or case, was seen as a possibility to further networking and a way to better the existing interaction.

Earlier contact between agencies

Again network meetings were seen as a good way to get to know the protocols and workings of the other agency. When the meeting takes place after a child

has received intensive care in a psychiatry inpatient ward, the need for communication, from the psychiatry professionals side no longer exists. The child is passed back to the residential care institution and a suggestion for outpatient care might be given, but there is no more communication between the inpatient ward staff and residential care staff.

Early introductions to different facilities and what they offer, lessens the chance of wrong decisions for care to be made. It was also seen that familiarization of protocols and the other institutions staff lowers the threshold of consulting the other professionals, when there is a situation which requires it.

6.3.3 Personal and professional development

Education in mental health conduct

The capacity of residential care workers addressing mental health problems expressed by an adolescent in their care was considered to be poor by the staff. It was seen there were no means to deal with an issue internally. The continuance of care for the adolescent was seen as an important part of residential care and with phone consulting was offered the staff wished to be educated in mental health more deeply, in order to handle some cases on their own. This education would bring clarity to situation assessment for the staff and give them means to handle cases internally better.

Better understanding of child placement protocol

The psychiatry professionals felt there needs to be further education for them on the protocols and workings of the social welfare side for their staff. They work from a different perspective than the child welfare professionals and would like further clarification of the interaction between residential care workers and the child's own social worker, how many welfare workers the child may have handling their case, what are the options the child has after receiving a customership in child welfare since the objective is not a lifelong customership, but to rehabilitate the child.

The knowledge of Mental Health Act was vast, but the staff felt they needed more in-depth knowledge of the Child Welfare Act and what the customership of residential care institution means for the child and how it affects the care given in psychiatry.

Understanding of resource optimizing

Getting an understanding on the most effective way to handle a situation, which needs cooperation from multiple agencies, would reduce extra strain and the involvement of unnecessary parties. This can be achieved by clarifying who to contact in certain cases and familiarization of protocols and options.

Staff education on laws related to child care

Joined education of psychiatry personnel and child welfare personnel was considered to be a desired outcome of this project. Case based work, where a case of a child is presented to both operators and discussed from both point of views would deepen the understanding of protocols and procedures for all involved. The psychiatry professionals would gain an understanding of the placement protocols and child welfare workers would gain an understanding of the clinical perspective of mental health care.

Both operators work for the best of the child, a patient centered approach, but the aspect of care each provides is slightly different; the psychiatry professionals' angle is clinical and a treatment of an illness where the residential care workers focus is educational.

7 RELIABILITY, VALIDITY AND ETHICS

The reliability and validity of this thesis including the research ethics are evaluated here.

Although among researches the emphasis is on avoiding mistakes and errors, reliability and validity of the researches varies. The reliability of the research refers to repeatable qualities of the research results. If the results are repeatable, not just random results, the reliability of the research can be demonstrated. In addition, the validity of the research refers to the study's ability to measure what it was meant to be measuring instead of getting answers for something else, which was not meant to be researched (Hirsjärvi et al. 2009, 231.).

One limitation, concerning this research, is that a discussion of results with other authors working under the RESME-project was not possible during the writing process of this thesis. This thesis is presented later than the before planned schedule, due to group changes. A systematic literature review was planned to compliment the results of the data analysis done for this work, but the writing process was shifted from two authors onto one.

The mixed focus group interviews were organized by RESME- project and the approval for interviews was granted for both residential care workers and the psychiatric inpatient ward workers. Participants chose to be included in the interviewing process by voluntary bases and were informed about the aim and purpose of the research prior to interviewing and in the beginning of both interviews. In addition the participants were reminded of the option to discontinue their participation at any point and that their anonymity was ensured in the transcription process.

The sample is small, consisting of five to six individuals. The participants were the same on both interviews so the sample size and participants as individuals varied by one participant only between the two interviews. Due to the size of the sample, generalization of results cannot be made.

The difficulties with showing the analyzing process was due to both the amount of qualitative data, with two transcriptions over 25 pages, and the process being scarcely discussed in literature (Elo, S. & Kyngäs, H., 2007). While the analysis was done with the same tools as previously published RESME- thesis by Kuosa and Cobo-Carretero, a different approach to translation process and condensing the meanings units was chosen. The writer of this thesis concluded the translation process to feel more natural earlier in the analysis process than author Kuosa, in order to preserve the contents of the source material.

Transcribing the interview had its own difficulties, due to similar sounding voices of the participants, but since the identification of the speaker was not considered as important as the content, this has very little weight on validity. However, due to external reasons and the nature of the interviews being semi structured, some words and entire phrases were lost under multiple participant speaking at the same time, or external sounds disrupting the recording of the interview.

The writer of this thesis has no translation related background, which gives a possibility for errors in the translation process. Before starting this thesis the writer had very little background on content analyzing and especially in the field of doing a qualitative content analysis, this can have an effect on the trustworthiness.

8 DISCUSSION

The results of the content analysis shows an existing cooperation between residential care institutions and psychiatry inpatient wards, while also explaining what are the problems and which elements cause these problems in the current cooperation. Results show the problems are within the systems and structures, but also there is a lack of knowledge of the inner workings of the other organization, which can lead to hinders in communication and therefor cooperation.

Even if the analysis was based on interviews participated by only 5-6 members, leaving the sample size small, the expertise of the participants was a substantial factor. The data analysis process demanded the writer also to familiarize their self with laws and the general situation of child protective services, to ensure an understanding of the topics discussed. Though the results are based on the work of one individual, findings can be rationalized by examining the transcripts of the interviews.

The work life consists increasingly of multiagency cooperation and multiprofessional teams in all fields, but this applies especially to social- and health care fields. This validates the experiences of the residential care workers and psychiatry professionals, who need cooperation daily in their work.

This experience based approach to the problems help find the concrete problems in cooperation and help the agencies involved improve their protocols and find the needs for education or improvement of their staff.

Majority of the improvements need either additional resources for professional development of the current staff or an increase of staff members with specialized knowledge.

Few points arouse from the setting of the interviews. Firstly, it would be interesting to study the cooperation of a social worker who makes placement decisions and residential care units. The interaction between these two operators seemed to have the most important role in the decision making of the child’s out of home

care. This also appeared to be the biggest obstruction in information transfer and other cooperation between agencies.

Secondly, the education methods and suggestions by the participants would be interesting to study. The effectiveness of problem- or case-based learning and the point of professional education could be studied. Can the teaching methods be implemented in bachelor's level education, or should this be implemented only into master degree programs or in-service training.

8.1 Conclusions

This thesis has explored the multiagency cooperation between residential care institutions and psychiatric inpatient ward staff, from the perspective of participants of a mixed focus group interview. It has shown positive possibilities for future cooperation to be present and highlighted the issues currently at hand.

Due to the continuous rise of cases where children and adolescents are in need of out of home placement, the current policies and means of multiagency communication and cooperation need to be examined. As a mandate for growth and betterment of communication and services provided, a more focused and detailed look on preventative care, in both mental health services and child protective services, should be adopted.

Further education and complimentary training for people working with children and adolescents helps to support a patient centered approach to care. Networking between agencies help set clear and common policies, familiarize with other institutions practices and produce clarity with information referral.

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Used transcription characters

Transcription of the focus group interview - Mixed focus group interview 13.3.

Used transcription characters

Interviewers:	H1, H2, H3
Interviewees:	P1, P2, and S1, S2, S3 in addition Vm = at the same time several interviewees, who were not able to be recognized separately
An unclear word	()
Interpretation of the word or a speaker	(text)
Writers comment/explanation	((text))
Simultaneous speaking	[ ]
Possible identifier made unrecognizable	”Name”, ”Number”, ”Locality”

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Result table of content analysis

1. GOOD		2. BAD			3. IDEAS		
1.1 Current good cooperation	1.2 Potential for proper cooperation	2.1 Systems and structures	2.2 Influencing factors	2.3 Abnormalities	3.1 What will/should changes affect?	3.2 Organizational and professional revision	3.3 Personal and professional development
1. Openness for cooperation	1. The already established network	1. Unclear progression of care for child with mental health problem	1. Confusion in cooperation and protocols	1. Obscurity in patient privacy practice	1. Clarify the steps for cooperation	1. Clear guidelines for mental health care assessment	1. Education in mental health conduct
2. Mutual respect between parties	2. Network meetings when possible	2. Feelings of lack of control in patient placements	2. Third party decision making	2. Decisions for care made without adequate knowledge	2. Ability to be involved in child placement decisions	2. More possibilities for multiagency cooperation	2. Better understanding of child placement protocol
3. Ability to consult professionals	3. Gradual familiarization for child between agencies	3. Lack of resources	3. Lack of adequate staff	3. Rushed care decisions		3. Earlier contact between agencies	3. Understanding of resource optimizing
4. Customer centered cooperation	4. Finding a common professional perspective	4. Difficulties in family centered care	4. Stigma	4. Parents negative attitude towards staff	4. Therapeutic and early interaction for child and mental health care staff		4. Staff education on laws related to child care